Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dipti Patel, D.C. c/o Pain & Recovery Clinic of North Houston 6660 Airline Dr. Houston, TX 77076	MFDR Tracking #: M4-07-7370-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: City of Houston Rep. Box #: 42	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "This provider was referred the patient from his treating doctor; therefore our facility is to be reimbursed. In addition, Dr. Patel is on the ADL. Dr. McMillan was approved to be this patient's treating doctor on 02/08/07. Our facility also had pre-authorization for these services."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $894.55
3. CMS 1500s
4. EOBs
5. Preauthorization Letter #MCGI01192007001 for 11 visits between 01/23/07 and 02/16/07 for 97110 initial PT 5 x 1 wk, then 3 x 2 wks, left ankle/97140, 97112.
6. Preauthorization Letter #MCGI03022007001 for 6 visits between 03/06/07 and 03/23/07 for 97110 post injection pt 3 x 2 wks, left ankle/97140, 97112.

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: None Submitted

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
02/21/07, 03/06/07, 03/08/07	99212	38, W4	1, 2, 3, 6, 10	$141.15
02/21/07, 02/27/07, 03/06/07, 03/08/07	97110	38, W4	1, 2, 4, 7, 10	$407.28
02/21/07, 02/27/07, 03/06/07, 03/08/07	97140	38, W4	1, 2, 4, 8, 10	$127.56
02/21/07, 02/27/07, 03/06/07, 03/08/07	97112	38, W4	1, 2, 4, 9, 10	$141.04
02/21/07, 02/27/07, 03/06/07, 03/08/07	97032	38, W4	1, 5	$0.00
Total Due:				$817.03

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "38 - Provider is not an Authorized Treating Physician" and "W4 - No additional payment allowed after review."
2. Physical therapy services were rendered by an ADL listed physician (Dr. Patel, D.C.) and referred by an authorized Treating Doctor (Dr. McMillan, M.D.) as of DWC-53 change on 02/08/07 therefore reimbursement for eligible preauthorized services according to Rule 134.202 are recommended.
3. The office visit CPT code 99212 is recommended for payment per 134.202.
4. Per 134.600, Physical therapy services were approved. However, The authorization limited treatment with CPT codes 97110, 97112, and 97140. These CPT codes are recommended for reimbursement.
5. CPT code 97032 is beyond the scope of the preauthorization approvals and reimbursement is not recommended per Rule 134.600.
6. CPT code 99212 has a MAR of $47.05 ($37.64 x 125%) x 3 DOS = $141.15 due to Requestor.
7. CPT code 97110 has a MAR of $33.94 ($27.15 x 125%) x 3 units x 4 DOS = $407.28 due to Requestor.
8. CPT code 97140 has a MAR of $31.89 ($25.51 x 125%) x 4 DOS = $127.56 due to Requestor.
9. CPT code 97112 has a MAR of $35.26 ($28.21 x 125%) x 4 DOS = $141.04 due to Requestor.
10. Per review of Box 32 on CMS-1500, zip code 77076 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

A legal and enforcement referral has been made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202, and Section 134.600.
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $817.03 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	01/17/08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.